STATE OF CALIFORNIA

REPORT OF LOSS, NONPERFORMANCE OR DAMAGE

PR-ENF-008 (EST. 9/94)

DEPARTMENT OF PESTICIDE REGULATION
ENFORCEMENT BRANCH

FILE NUMBER ***(For County Use Only***

TO: (AGRICULTURAL COMMISSIONER)

COUNTY

In accordance with Sections 11761 through 11765 of the Food and Agricultural Code, the following **Report of Loss** is submitted:

CLAIMANTS NAME

TELEPHONE NUMBER

ADDRESS OR POST OFFICE BOX NO.

CITY

STATE

ZIP CODE

TYPE OF PROPERTY ALLEGEDLY INJURED OR DAMAGED

ACRES OR UNITS

FULLY DESCRIBE ALLEGED INJURY OR DAMAGE (Include symptoms, when first noticed, etc.)

LOCATION OF PROPERTY ALLEGEDLY INJURED OR DAMAGED

SECTION

TOWNSHIP

RANGE

BASE & MERIDIAN

DATE THE ALLEGED INJURY OR DAMAGE OCCURRED

TIME

NAME OF PERSON OR FIRM ALLEGEDLY RESPONSIBLE FOR LOSS OR DAMAGE

NAME OF OWNER OR OCCUPANT OF PROPERTY FOR WHOM SUCH PERSON OR FIRM WAS RENDERING LABOR OR SERVICES

LOCATION OF SUCH PROPERTY

ADDITIONAL INFORMATION

I declare under penalty of perjury that the above is true and correct

CLAIMANT'S SIGNATURE

DATE

Filing Information on Reverse Side of Form

STATE OF CALIFORNIA DEPARTMENT OF PESTICIDE REGULATION

SAMPLE ANALYSIS REPORT

PR-ENF-030 (REV. 11/05)

Important:
1. Use only one analysis report form per sample.
2. Complete chain of evidence record on reverse.
3. Use black ink and print legibly.
4. The original will be returned to you.

For Laboratory Use Only

LABORATORY CONDUCTING ANALYSIS

☐ ANAHEIM ☐ SACRAMENTO

DATE SAMPLE RECEIVED | TIME RECEIVED

LABORATORY NUMBER

A. Sample Analysis Requester

AGENCY NAME (Complete name) | TELEPHONE NUMBER ( ) | FAX NUMBER ( )

ADDRESS | CITY | STATE | ZIP CODE

B. Sample Source

PROPERTY OPERATOR/COMPLAINANT NAME | OPERATOR IDENTIFICATION OR PERMIT NO. | TELEPHONE NUMBER ( )

ADDRESS

CITY | STATE | ZIP CODE

SECTION, TOWNSHIP, RANGE | SAMPLE LOCATION (Address or Description) | SITE IDENTIFICATION NUMBER | COUNTY

C. Sample Information

SAMPLE CONSISTS OF:

COMMODITY (Acres, if applicable) | SAMPLE IDENTIFICATION MARKS

BASIS FOR SAMPLE (Check one box, only)
☐ HEALTH HAZARD ☐ ANIMAL ILLNESS/BEE LOSS ☐ PLANT SYMPTOMS ☐ ENVIRONMENTAL EFFECTS

IS THIS A CONTROL SAMPLE? ☐ YES ☐ NO

IS THIS SAMPLE A COMPOSITE? ☐ YES ☐ NO

DESCRIPTION OF PROBLEM

SAMPLE COLLECTOR'S SIGNATURE | PRINT NAME | DATE SAMPLE COLLECTED

D. Laboratory Instructions

SAMPLE PRIORITY (Priority descriptions on reverse side of this form) ☐ #1 ☐ #2 ☐ #3

SAMPLE DISCARD DATE | COMMENTS

E. Specific Analysis Requested

	PESTICIDE DETECTED	AMOUNT	UNITS	MDL	EXT CODE	DET CODE
☐ _____		.				
☐ _____		.				
☐ _____		.				
SCREENS						
☐ ORGANOPHOSPHATE (OP)		.				
☐ CARBAMATE (CARB)		.				
☐ CHLORINATED HYDROCARBON (CHC)		.				

☐ SURFACE/SWAB (Indicate Total Surface Area)_____)

☐ SURFACE/SWAB (Indicate Solvent Used) _____)

☐ DISLODGEABLE (Indicate Punch Size)_____)

DATE ANALYSIS COMPLETED

CONFIRMED BY | CHEMIST'S SIGNATURE

RESULTS: ☐ FAXED ☐ PHONED DATE _____ | SAMPLE REJECTED

You must complete the custody record on reverse side of this form or samples may not be analyzed.

SAMPLE ANALYSIS REPORT CUSTODY RECORD

F. Sample Information

SAMPLE COLLECTOR (Print name)	SAMPLE IDENTIFICATION MARKS	LABORATORY NUMBER

G. Preservation Method During Transport

☐ Ice ☐ Dry Ice ☐ "Blue" Ice ☐ Cooler ☐ Cool Dry Container ☐ Other _____ ☐ None

H. Primary Container Description

☐ Paper Bag ☐ Plastic Bag ☐ Glass Jar ☐ Plastic Jar ☐ Amber Jar ☐ Other _____

I. Transportation Information

REGIONAL / SATELLITE OFFICE ORIGIN

☐ Anaheim (SRO) ☐ Watsonville

☐ Bakersfield ☐ Other _____

☐ Fresno (CRO)

☐ Sacramento (NRO)

NAME OF COMMON CARRIER (If used)

SHIPPING INVOICE NUMBER

DOT NUMBER/CLASSIFICATION (If necessary)

DATE SAMPLE SHIPPED | TIME

I certify that the above-listed sample is property classified, described, packaged, marked, and labeled.
I additionally certify that this sample analysis is necessary in connection with matters relating to my official duties.

SIGNATURE	PRINT NAME	DATE

DESTINATION

Check One

☐ CA Department of Food and Agriculture
Center for Analytical Chemistry
3292 Meadowview Road
Sacramento, California 95832
(916) 262-1574, FAX - (916) 262-1564

☐ Anaheim Residue Laboratory
169 East Liberty Avenue
Anaheim, California 92801
(714) 680-7919, FAX - (714) 680-7901

CONTACT

NRO (916) 324-4100, FAX - (916) 445-7083
CRO (559) 243-8111, FAX - (559) 243-8115
SRO (714) 279-7690, FAX - (714) 279-7692

J. Custody Record When Hand Carried ***(PRINT NAME)***

RECEIVED FROM (Sample Collector or Common Carrier)	DELIVERED TO	DATE	TIME	PURPOSE
1.	*2.*			
RECEIVED FROM	DELIVERED TO	DATE	TIME	PURPOSE
2.	*3.*			
RECEIVED FROM	DELIVERED TO	DATE	TIME	PURPOSE
3.	*4.*			
RECEIVED FROM	DELIVERED TO	DATE	TIME	PURPOSE
4.	*5.*			

K. Laboratory Storage

SAMPLE RECEIVED BY (PRINT NAME)	DATE RECEIVED	TIME	SAMPLE CONDITION UPON RECEIPT (Lab Use Only)
STORAGE LOCATION	STORAGE DATE (If applicable)	TIME	

SAMPLE PRIORITIZATION

Priority 1: Samples where immediate preventative or remedial action can be taken to treat exposed persons or animals or to protect people from exposure. Analysis goal for screens is 24 hours from receipt by the laboratory. Specific analyses will take longer. Analytical results will be telephoned/faxed to the requester. The original analysis report will be mailed to DPR Regional Office.

Priority 2: Samples related to other human effects episodes identified as priority investigations. Analysis goal is 30 days. Results will be telephoned/faxed upon request. The original analysis report will be sent by mail to DPR Regional Office.

Priority 3: Other evidentiary samples. Analysis goal is 90 days, however, workload generated by status samples 1 and 2 may impact completion date. The original analysis report will be sent by mail to DPR Regional Office.

PROPER SAMPLE SIZE AND APPROVAL FOR ANALYSIS

Refer to the Evidence Collection section of the Investigation Procedures Standards Manual for proper sample sizes. **You must obtain approval from your DPR Enforcement Branch Liaison or regional office prior to submitting samples for laboratory analysis.**

DIAL 9-1-1 IN CASE OF ANY EMERGENCY

STATE OF CALIFORNIA

ENFORCEMENT/COMPLIANCE ACTION SUMMARY

PR-ENF-046 (REV. 6/01)

DEPARTMENT OF PESTICIDE REGULATION
ENFORCEMENT BRANCH

INSTRUCTIONS: (Please see reverse for codes and instructions.)

A. ENFORCEMENT/COMPLIANCE ACTION TYPE and STATUS. *(Only one enforcement type or compliance group, per form.)*

Date of Incident REIGHT OF WAY	Date of Action	Date Closed	Susp/Revok Date	Case Number (numeric only)	County

Administrative Action (check only one):

- ☐ Administrative Civil Penalty (Agricultural)
- ☐ Administrative Civil Penalty (Structural)
- ☐ County Registration Suspended/Revoked
- ☐ Private Applicator Certificate Suspended/Revoked
- ☐ Restricted Materials Permit Suspended/Revoked

Referred for State Action: ☐ DPR ☐ SPCB ☐ OTHER

Judicial Action (check only one):

- ☐ Notice to Appear (Citation)
- ☐ Case Submitted to DA/Circuit Prosecutor

follow up →
- ☐ Civil Complaint Filed
- ☐ Criminal Complaint Filed

Compliance Actions (check all that apply):

- ☐ Cease and Desist Order
- ☐ Documented Compliance Interview
- ☐ Warning Letter/Violation Notice (VN)

Administrative Action Status (check one):

- ☐ Notice of Proposed Action (NOPA)

OR

- ☐ Signed Stipulation ☐ Withdrawn
- ☐ Closed After Hearing ☐ Closed No Hearing

Action Reference:

DPR Priority Investigation #: _____

Worker Health and Safety (WHS) Case #: _____

District Attorney/Prosecutor Case #: _____

Other Case # or Inspection Date: _____

B. ACTION DETAIL. *(Attach additional page(s) as necessary.)*

SECTION(S) CITED (One per line)	PROPOSED Fine ($)	PROPOSED Suspension (days)	MODIFIED Fine ($)	MODIFIED Suspension (days)	DISMISSED (Check if dismissed)
					☐
					☐
					☐
					☐
Cont ☐					☐

C. INDIVIDUAL/BUSINESS INFORMATION. *If the individual is affiliated with a business or organization, you may complete both individual and business sections. Indicate whether the individual (IND) or business/organization (BUS) is being cited in this action by checking the appropriate 'respondent' box:*

IND ☐	Last Name	First Name	M.I.	License Code	Individual License Number	If Unregistered, ☐ Check Box
BUS ☐	Business/Organization Name			License Code	Business License Number	If Unregistered, ☐ Check Box

Employment Code (see reverse)	SPCB Branch	☐ Operator ID # ☐ Restricted Materials Permit #	Private Applicator Certificate Number

D. ACTIVITY/INCIDENT INFORMATION. ***See Reverse for Codes**

PESTICIDE PRODUCT NAME(S)	PRODUCT REG. NUMBER	*Category	*Setting	*Activity
		Comment on Category/Setting/Activity:		
County Contact (please print):	Telephone			

STATE OF CALIFORNIA

COMPLAINT OF HUMAN EXPOSURE OR UNSAFE CONDITION

PR-ENF-074 (EST. 9/94)

DEPARTMENT OF PESTICIDE REGULATION
ENFORCEMENT BRANCH

COMPLAINANT'S NAME			TELEPHONE NUMBER (Include area code) ( )
ADDRESS	CITY	STATE	ZIP CODE

DATE OCCURRED	NUMBER OF PERSONS EXPOSED TO CONDITION:	IS EXPOSURE CONTINUING? YES ☐ NO ☐	WAS A DOCTOR SEEN? YES ☐ NO ☐	DOCTOR'S TELEPHONE (Include area code) ( )

DOCTOR'S NAME	DOCTOR'S ADDRESS

LOCATION OF EXPOSURE OR CONDITION (Be Specific)

	COUNTY

DESCRIPTION OF EXPOSURE OR CONDITION

NAME OF PESTICIDE/MANUFACTURER	REGISTRATION NUMBER FROM LABEL
DOSE/DILUTION/VOLUME	COMMODITY/SITE TREATED
NAME OF PERSON OR FIRM ALLEGEDLY RESPONSIBLE	OWNER OR OPERATOR OF PROPERTY TREATED

OCCUPATIONAL SITUATION YES ☐ NO ☐	OCCUPATION

Important! You do not need to complete this portion of the form unless the complaint is the result of an occupational situation.

EMPLOYER'S NAME			TELEPHONE NUMBER (Include area code) ( )
ADDRESS	CITY	STATE	ZIP CODE
TYPE OF BUSINESS			
SUPERVISOR'S NAME	TITLE		

COMPLAINANT IS: ☐ FORMAL ☐ INFORMAL

EMPLOYEE CONFIDENTIALITY PURSUANT TO SECTION 6309 OF THE LABOR CODE:

I PERMIT THE DISCLOSURE OF MY NAME YES ☐ NO ☐

I PERMIT THE DISCLOSURE OF THIS INFORMATION YES ☐ NO ☐

I hereby certify that the above, to the best of my knowledge, is true and correct.

CLAIMANT'S SIGNATURE	DATE
PERSON RECEIVING THE COMPLAINT (Print name) / TITLE	DATE

Complainant: This form must be signed and dated prior to submission.

STATE OF CALIFORNIA

PESTICIDE ILLNESS INVESTIGATION REQUEST FOR TIME EXTENSION

PR-ENF-097 (EST. 8/98)

DEPARTMENT OF PESTICIDE REGULATION
ENFORCEMENT BRANCH

County	Senior Pesticide Use Specialist
Priority Number	Regional Office
WH&S Case Number	Date Opened
Case Name	Date Received

Justification for extension.

- ☐ The injured person is unavailable for an extended period of time, but is expected to be available for an interview at a later date.
  Approximate date of availability is: _____
- ☐ Samples have been sent to an analytical laboratory which is unable to return the results for an extended period of time.
  Approximate date of availability is: _____
- ☐ There is a delay in obtaining medical records or coroner reports.
  Approximate date of availability is: _____
- ☐ Other. Explain. _____

Expected Completion Date:

REQUESTER'S SIGNATURE			DATE REQUESTED	
☐ Approved ☐ Denied	REQUEST APPROVED/ DENIED BY		DATE APPROVED/DENIED	

STATE OF CALIFORNIA

PESTICIDE EPISODE INVESTIGATION REPORT

PR-ENF-127 (REV. 7/00)

DEPARTMENT OF PESTICIDE REGULATION
PESTICIDE ENFORCEMENT BRANCH

PAGE _____ OF _____

RECEIVED BY	RECEIVED FROM	REPRESENTING	DATE/TIME RECEIVED ☐ AM ☐ PM	PERSON NOTIFIED / DATE
				DFA
				DFG
				DHS
				DIR
				EPA
				CAC
				OTHER

TYPE OF EPISODE
☐ HUMAN EFFECTS # _____ ☐ ENVIRONMENTAL EFFECTS
☐ PROPERTY LOSS $ _____ ☐ OTHER

PRIORITY INVESTIGATION
☐ YES # _____ ☐ NO

OTHER I.D. NO.	COUNTY OF OCCURRENCE	DATE OF OCCURRENCE MO DAY YR	TIME ☐ AM ☐ PM

EPISODE LOCATION

INJURED/COMPLAINANT INFORMATION

COMPLAINT SIGNED ☐ YES ☐ NO ☐ N/A

DR. VISITED ☐ YES ☐ NO ☐ N/A

EXTENT OF INJURY/ILLNESS
☐ Fatal ☐ Symptoms
☐ Serious ☐ Exposed Only

ACTIVITY OF PERSON EXPOSED/INVOLVED
☐ Mixer/Loader ☐ Field Worker* ☐ Other*
☐ Applicator ☐ Public* Explain _____

NAME	AGE	SEX	WHS NO.	WORKDAYS LOST

ADDRESS	CITY	ZIP	PHONE

MEDICAL FACILITY NAME	☐ TREATMENT PROVIDED ☐ OBSERVATION ONLY	HOSPITALIZED ☐ YES ☐ NO	DATE/TIME ADMITTED	DATE/TIME DISCHARGED

PHYSICIAN	ADDRESS	PHONE

SIGNS/SYMPTOMS EXPERIENCED

EMPLOYER	ADDRESS	PHONE

PROTECTIVE MEASURES USED

EYES
☐ Safety Glasses
☐ Goggles
☐ Faceshield
☐ Eye/Sun Glasses
☐ None

HANDS
☐ Cloth/Leather Gloves
☐ Chem. Resistant Gloves
☐ Other _____
☐ None

INHALATION
☐ Dust Mask
☐ 1/2 Face Respirator
☐ Full Face Respirator
☐ SCBA
☐ None

OTHER
☐ Work Clothes
☐ Coveralls _____
☐ Chem. Resistant Clothes
☐ Chem. Resistant Boots
☐ Head Covering
☐ Other _____

ENGINEERING CONTROLS
☐ Closed System
☐ Enclosed Cab
☐ Enc. Cab w/Air Purification
☐ Other _____
☐ None

ENVIRONMENTAL OR PROPERTY DAMAGE

DESCRIPTION OF DAMAGE	AMOUNT/VALUE

OWNER	ADDRESS	PHONE

ALLEGED RESPONDENT(S)

PCA ☐ DEALER ☐ PILOT ☐ GROWER ☐ AGENCY ☐ OTHER* ☐

NAME	PHONE	LICENSE/PERMIT NO.	RECOMMENDATION MADE ☐ YES # _____ ☐ NO

ADDRESS	EMPLOYER'S NAME	PHONE

CITY	STATE	ZIP	EMPLOYER'S ADDRESS

EXPLAIN*	CITY	STATE	ZIP

PESTICIDE NAME/MANUFACTURER	EPA REGISTRATION NUMBER	CATEGORY	DOSE/DILUTION/VOLUME	TREATMENT DATE	COMMODITY/SITE TREATED

EQUIPMENT TYPE/MAKE/MODEL/DESCRIPTION

SUMMARIZE THE EPISODE INCLUDING A DETAILED DESCRIPTION OF EVIDENCE TAKEN (Use Episode Report Supplement Form PR-ENF-127A If Additional Space Is Needed)

REPORT PREPARED BY (NAME/TITLE)	DATE PREPARED	REPORT REVIEWED/APPROVED BY (NAME/TITLE)	DATE APPROVED

STATE OF CALIFORNIA

PESTICIDE EPISODE INVESTIGATION SUPPLEMENTAL REPORT

PR-ENF-127A (REV. 7/00)

DEPARTMENT OF PESTICIDE REGULATION
PESTICIDE ENFORCEMENT BRANCH

PAGE _____ OF _____

LOCATION/SUBJECT	PRIORITY/WHS NO.	OTHER I.D. NO.	COUNTY OF OCCURRENCE	DATE OF OCCURRENCE MO DAY YR

REPORT/TYPE

☐ NARRATIVE CONTINUATION ☐ SUPPLEMENTAL REPORT ☐ OTHER REPORT _____

REMARKS

REPORT PREPARED BY (NAME/TITLE)	DATE PREPARED	REPORT REVIEWED/APPROVES BY (NAME/TITLE)	DATE/APPROVED

STATE OF CALIFORNIA

EPISODE WITNESS/INJURED/COMPLAINANT REPORT

PR-ENF-127B (REV. 1/98)

DEPARTMENT OF PESTICIDE REGULATION
ENFORCEMENT BRANCH

PAGE _____ OF _____

PRIORITY INVESTIGATION ☐ YES # _____ ☐ NO | **OTHER I.D. NO.** | **COUNTY OF OCCURRENCE** | **DATE OF OCCURRENCE** MO DAY YR

COMPLAINT SIGNED ☐ YES ☐ NO ☐ N/A | **DR. VISITED** ☐ YES ☐ NO ☐ N/A | **EXTENT OF INJURY/ILLNESS** ☐ Fatal ☐ Symptoms ☐ Serious ☐ Exposed Only | **ACTIVITY OF PERSON EXPOSED/INVOLVED** ☐ Mixer/Loader ☒ Field Worker* ☐ Other* ☐ Applicator ☐ Public* Explain _____

WITNESS/INJURED/COMPLAINANT

NAME | AGE | SEX | WHS NO. | WORKDAYS LOST

ADDRESS | CITY | ZIP | PHONE

MEDICAL FACILITY NAME | ☐ TREATMENT PROVIDED ☐ OBSERVATION ONLY | HOSPITALIZED ☐ YES ☐ NO | DATE/TIME ADMITTED | DATE/TIME DISCHARGED

PHYSICIAN | ADDRESS | PHONE

SIGNS/SYMPTOMS EXPERIENCED

EMPLOYER | ADDRESS | PHONE

PROTECTIVE MEASURES USED

EYES	HANDS	INHALATION	OTHER	ENGINEERING CONTROLS
☐ Safety Glasses	☐ Cloth/Leather Gloves	☐ Dust Mask	☐ Work Clothes	☐ Closed System
☐ Goggles	☐ Chem. Resistant Gloves	☐ 1/2 Face Respirator	☐ Coveralls _____	☐ Enclosed Cab
☐ Faceshield	☐ Other _____	☐ Full Face Respirator	☐ Chem. Resistant Clothes	☐ Enc. Cab w/Air Purification
☐ Eye/Sun Glasses	☐ None	☐ SCBA	☐ Chem. Resistant Boots	☐ Other _____
☐ None		☐ None	☐ Head Covering	☐ None
			☐ Other _____	

COMPLAINT SIGNED ☐ YES ☐ NO ☐ N/A | **DR. VISITED** ☐ YES ☐ NO ☐ N/A | **EXTENT OF INJURY/ILLNESS** ☐ Fatal ☐ Symptoms ☐ Serious ☐ Exposed Only | **ACTIVITY OF PERSON EXPOSED/INVOLVED** ☐ Mixer/Loader ☐ Field Worker* ☐ Other* ☐ Applicator ☐ Public* Explain _____

WITNESS/INJURED/COMPLAINANT

NAME | AGE | SEX | WHS NO. | WORKDAYS LOST

ADDRESS | CITY | ZIP | PHONE

MEDICAL FACILITY NAME | ☐ TREATMENT PROVIDED ☐ OBSERVATION ONLY | HOSPITALIZED ☐ YES ☐ NO | DATE/TIME ADMITTED | DATE/TIME DISCHARGED

PHYSICIAN | ADDRESS | PHONE

SIGNS/SYMPTOMS EXPERIENCED

EMPLOYER | ADDRESS | PHONE

PROTECTIVE MEASURES USED

EYES	HANDS	INHALATION	OTHER	ENGINEERING CONTROLS
☐ Safety Glasses	☐ Cloth/Leather Gloves	☐ Dust Mask	☐ Work Clothes	☐ Closed System
☐ Goggles	☐ Chem. Resistant Gloves	☐ 1/2 Face Respirator	☐ Coveralls _____	☐ Enclosed Cab
☐ Faceshield	☐ Other _____	☐ Full Face Respirator	☐ Chem. Resistant Clothes	☐ Enc. Cab w/Air Purification
☐ Eye/Sun Glasses	☐ None	☐ SCBA	☐ Chem. Resistant Boots	☐ Other _____
☐ None		☐ None	☐ Head Covering	☐ None
			☐ Other _____	

COMPLAINT SIGNED ☐ YES ☐ NO ☐ N/A | **DR. VISITED** ☐ YES ☐ NO ☐ N/A | **EXTENT OF INJURY/ILLNESS** ☐ Fatal ☐ Symptoms ☐ Serious ☐ Exposed Only | **ACTIVITY OF PERSON EXPOSED/INVOLVED** ☐ Mixer/Loader ☐ Field Worker* ☐ Other* ☐ Applicator ☐ Public* Explain _____

WITNESS/INJURED/COMPLAINANT

NAME | AGE | SEX | WHS NO. | WORKDAYS LOST

ADDRESS | CITY | ZIP | PHONE

MEDICAL FACILITY NAME | ☐ TREATMENT PROVIDED ☐ OBSERVATION ONLY | HOSPITALIZED ☐ YES ☐ NO | DATE/TIME ADMITTED | DATE/TIME DISCHARGED

PHYSICIAN | ADDRESS | PHONE

SIGNS/SYMPTOMS EXPERIENCED

EMPLOYER | ADDRESS | PHONE

PROTECTIVE MEASURES USED

EYES	HANDS	INHALATION	OTHER	ENGINEERING CONTROLS
☐ Safety Glasses	☐ Cloth/Leather Gloves	☐ Dust Mask	☐ Work Clothes	☐ Closed System
☐ Goggles	☐ Chem. Resistant Gloves	☐ 1/2 Face Respirator	☐ Coveralls _____	☐ Enclosed Cab
☐ Faceshield	☐ Other _____	☐ Full Face Respirator	☐ Chem. Resistant Clothes	☐ Enc. Cab w/Air Purification
☐ Eye/Sun Glasses	☐ None	☐ SCBA	☐ Chem. Resistant Boots	☐ Other _____
☐ None		☐ None	☐ Head Covering	☐ None
			☐ Other _____	

COMMENTS

REPORT PREPARED BY (NAME/TITLE)	DATE PREPARED	REPORT REVIEWED/APPROVED BY (NAME/TITLE)	DATE PREPARED

STATE OF CALIFORNIA

EPISODE SITE DIAGRAM

PR-ENF-127C (EST.10/91)

DEPARTMENT OF PESTICIDE REGULATION
PESTICIDE ENFORCEMENT BRANCH

PAGE _____ OF _____

LOCATION/SUBJECT	PRIORITY/WHS NO.	OTHER I.D. NO.	COUNTY OF OCCURRENCE	DATE OF OCCURRENCE MO DAY YR

INSTRUCTIONS: ***Make All Measurements Approximate Unless Diagram is to Scale (Indicate Scale Used)***

LEGEND AND COMMENTS (*Use Pesticide Episode Investigation Supplemental Report If Additional Space for comments is Needed)*

STATE OF CALIFORNIA

FIELD WORKER DERMATITIS SUPPLEMENTAL REPORT

PR-ENF-127D (EST. 10/91)

DEPARTMENT OF PESTICIDE REGULATION
PESTICIDE ENFORCEMENT BRANCH

PAGE _____ OF _____

WHS NUMBER	OTHER I.D. NO.	COUNTY OF OCCURRENCE	DATE OF OCCURRENCE MO DAY YR

PERSON(S) PROVIDING INFORMATION

PERSON(S) CONTACTED DURING THE INVESTIGATION

☐ EMPLOYEE ☐ EMPLOYER ☐ SUPERVISOR/FOREMAN ☐ CO-WORKER ☐ RELATIVE ☐ OTHER

DID ABOVE PERSON(S) SPEAK ENGLISH? ☐ YES ☐ NO TRANSLATOR'S NAME _____

COMMODITY AND WORK ACTIVITY INFORMATION

CAN THE ONSET OF SYMPTOMS BE IDENTIFIED ☐ YES ____/____/____ ☐ NO

COMMODITY TREATED _____ SITE I.D. NUMBER _____ BLOCK I.D. _____ VARIETY TREATED _____

DERMATITIS SYMPTOMS EXPERIENCED

☐ DUSTY ☐ POISON OAK ☐ RAGWEED/MAYWEED ☐ GENERALLY WEEDY ☐ BITING INSECTS ☐ WET ☐ OTHER _____

SPECIFIC WORK ACTIVITY AT ONSET OF SYMPTOMS (LAST 2 TO 3 DAYS)

☐ WEEDING ☐ PRUNING ☐ PULLING LEAVES ☐ TIPPING ☐ TURNING CANE ☐ PROPPING

☐ HARVESTING ☐ IRRIGATING ☐ THINNING ☐ OTHER _____

APPLICATION HISTORY (LAST 30 TO 60 DAYS) FOR FIELD OF ONSET

PESTICIDE NAME/MANUFACTURER	*EPA REGISTRATION NUMBER*	*APPLICATION METHOD**	*APPLICATION RATE*	*DILUTION RATE*	*TREATMENT DATE*

**Key: GE - Ground/Electrostatic; GOVB - Ground/Over Vine Boom; GAB - Ground/Air Blast; GB - Ground Boom; AH - Helicopter; AF - Aerial/Fixed Wing; O - Other*

APPLICATION HISTORY SUPPLIED BY

(NAME/TITLE) _____

NO. DAYS BETWEEN LAST APPLICATION AND ENTRY BY THIS EMPLOYEE _____

EXPOSURE INFORMATION AND MEDICAL HISTORY

DERMATITIS SYMPTOMS EXPERIENCED

☐ BURNING ☐ ITCHING ☐ BLISTERS ☐ DISCOLORATIONS ☐ HIVES ☐ OTHER _____

LOCATION(S) ON BODY

☐ NECK ☐ CHEST/ABDOMEN ☐ BACK ☐ LEGS ☐ FACE/HEAD ☐ HANDS ☐ FOREARM

☐ UPPER ARM ☐ FRONT OF ELBOW ☐ OTHER _____

PREVIOUS MEDICAL HISTORY

☐ DERMATITIS ☐ ASTHMA ☐ HAY FEVER ☐ CHILDHOOD ECZEMA ☐ NONE ☐ OTHER _____

PROTECTIVE CLOTHING/EQUIPMENT WORN

☐ LONG SLEEVES ☐ LONG PANTS ☐ GLOVES/CLOTH ☐ GLOVES/RUBBER ☐ SHOES/SOCKS ☐ OTHER _____

COMMENTS

REPORT PREPARED BY (NAME/TITLE)	DATE PREPARED	REPORT REVIEWED/APPROVED BY (NAME/TITLE)	DATE APPROVED

STATE OF CALIFORNIA

MEDICAL INFORMATION AUTHORIZATION

PR-ENF-133 (REV. 02/04)

DEPARTMENT OF PESTICIDE REGULATION
ENFORCEMENT BRANCH

I hereby authorize

PHYSICIAN OR HOSPITAL

ADDRESS

CITY, STATE AND ZIP CODE

to furnish to

NAME OF RECIPIENT OR RESPONSIBLE AGENCY

Department of Pesticide Regulation

ADDRESS

CITY, STATE AND ZIP CODE

Medical records and all information pertinent to medical care, treatment, hospitalization and/or outpatient care received by (self, child, or ward)_____ in regard to (describe incident)

which occurred in_____ county on (date or dates) _____

- I understand the purpose of providing this information is to assist in the investigation of the above incident, and any associated legal or administrative action connected with the incident.
- I understand that this information will be used by the County Agricultural Commissioner's office in the above-listed county and by the Department of Pesticide Regulation. Such release will aid in the investigation of the incident described above.
- I understand information disclosed pursuant to this authorization could be re-disclosed by the recipient and may on longer be protected by federal confidentiality laws (HIPAA). However, under the Information Practices Act of 1977 (California Civil Code 1798 et seq.), the requestor may not further use or disclose the medical information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law pursuant to state confidentiality laws.
- This authorization may be revoked at any time. My revocation will be effective upon receipt, but will have no impact on uses or disclosures made while my authorization was valid.
- This authorization expires six months after the date of signature, or as specified
- I have received a copy of this authorization.
- A photocopy of this authorization may be used the same as the original.

AUTHORIZING SIGNATURE (MAY BE SIGNED INDIVIDUALLY OR AS PARENT OR GUARDIAN)	DATE
WITNESS	DATE

DISTRIBUTION WHITE - FILE CANARY - PHYSICIAN OR HOSPITAL PINK - AUTHORIZING SIGNATURE OR PATIENT

ESTADO DE CALIFORNIA

AUTORIZACIÓN DE INFORMACIÓN MÉDICA

PR-ENF-133X (REV. 02/04)

DEPARTAMENTO DE REGLAMENTACIÓN DE PESTICIDAS
RAMA DEL CUMPLIMIENTO DE LEYES

Por este medio yo autorizo

MÉDICO U HOSPITAL

DIRECCIÓN

CIUDAD, ESTADO Y CODIGO POSTAL

para proporcionar a

NOMBRE DEL RECIBIDOR O AGENCIA RESPONSABLE

DIRECCIÓN

CIUDAD, ESTADO Y CODIGO POSTAL

Registros médicos y toda la información relacionada con el cuidado médico, tratamiento, hospitalización y/o paciente externo (que no queda en el hospital o clínica), cuidado recibido por (propio, niño, o menor bajo tutela)_____con relación a (describir el incidente)

Que ocurrió en el condado de _____en (fecha o fechas)_____

- Yo entiendo que el propósito de entregar esta información es para asistir en la investigación del incidente mencionado arriba, y cualquiera acción legal o administrativa relacionada con el incidente.
- Yo entiendo que esta información será usada por la oficina del Comisionado Agrícola del Condado y en el condado mencionado en la lista de arriba, y también por el Departamento de Reglamentación de Pesticidas. Tal declaración, ayudará en la investigación del incidente descrito arriba.
- Yo entiendo que la información revelada de acuerdo con esta autorización, podría ser revelada nuevamente por el recibidor y no estaría protegida por más tiempo bajo las leyes federales de confidencialidad (HIPAA, por su sigla en inglés). Sin embargo, bajo la Ley de 1977 de las Prácticas de Información (Código Civil de California § 1798 et seq.), el solicitante en adelante, no puede usar ni tampoco revelar la información médica. Salvo que se obtenga de mí otra autorización, o a menos que tal uso o declaración se requiera o se permita específicamente por ley, de acuerdo a las leyes estatales de confidencialidad.
- Esta autorización puede ser cancelada en cualquier momento. Mi cancelación será efectiva en el momento de recibirla, pero no tendrá efecto en usos o declaraciones hechas mientras mi autorización era valida.
- Esta autorización expira seis meses después de la fecha de mi firma, o como se especifique_____.
- Yo recibí una copia de esta autorización.
- Una fotocopia de esta autorización puede usarse en lugar del original.

FIRMA AUTORIZADORA (PUEDE FIRMAR INDIVIDUALMENTE O COMO PADRE O TUTOR)	FECHA
TESTIGO	FECHA

DISTRIBUCIÓN ARCHIVO - BLANCO COLOR CANARIO - MÉDICO U HOSPITAL ROSADO - FIRMA AUTORIZADORA O PACIENTE

DEPARTMENT OF PESTICIDE REGULATION

ANTIMICROBIAL EXPOSURE EPISODE REPORT

PR-ENF-182 (EST. 10/91)

DEPARTMENT OF PESTICIDE REGULATION
PESTICIDE ENFORCEMENT BRANCH

PAGE _____ OF _____

PRIORITY/WHS NUMBER	OTHER IDENTIFICATION NUMBER	COUNTY OF OCCURRENCE	DATE OF OCCURRENCE MO DAY YR

INJURED PERSON'S NAME	ADDRESS	AGE	SEX	DAYS IN HOSPITAL	WORK DAYS LOST

EMPLOYER NAME	ADDRESS	TYPE OF BUSINESS

SPECIFIC WORK ACTIVITY AT TIME OF EXPOSURE (i.e., Cleaning Tables, Mopping Floors, Etc.)

SITE/AREA TREATED

SIGNS/SYMPTOMS EXPERIENCED

PROTECTIVE MEASURES USED AT TIME OF INCIDENT

EYE PROTECTION

☐ GOGGLES ☐ FACESHIELD ☐ SAFETY GLASSES ☐ EYE/SUN GLASSES ☐ NONE

☐ OTHER _____

HAND/ARM PROTECTION

☐ CHEM. RESISTANT GLOVES (WRIST LENGTH) ☐ CHEM. RESISTANT GLOVES (ELBOW LENGTH) ☐ DISPOSABLE GLOVES

☐ CLOTH/LEATHER GLOVES ☐ NONE ☐ OTHER _____

OTHER PROTECTIVE EQUIPMENT

☐ CHEM. RESISTANT CLOTHES ☐ CHEM. RESISTANT BOOTS ☐ DISPOSABLE COVERALLS ☐ CLOTH COVERALLS

☐ RESPIRATORY PROTECTION TYPE _____ ☐ ENGINEERING CONTROL(S) TYPE _____ ☐ NONE ☐ OTHER _____

PESTICIDE NAME/MANUFACTURER	EPA REGISTRATION NUMBER	CATEGORY	DOSE/DILUTION/VOLUME	TREATMENT DATE

SUMMARY OF EXPOSURE EPISODE (Use Pesticide Episode Investigation Supplemental Report If Additional Space is Needed)

REPORT PREPARED BY (NAME/TITLE)	DATE PREPARED	REPORT REVIEWED/APPROVED BY (NAME/TITLE)	DATE APPROVED

State of California
Department of Pesticide Regulation
Departamento de Reglamentación de Pesticidas
DPR-071 (Est. 7/05)

Clothing Release Form
Formulario para Entregar la Ropa

List and describe clothing Enumere los artículos de ropa	Days Worn Días Usado	Estimated Value Valor Estimado	Sample Number
1.		$	
2.		$	
3.		$	
4.		$	
5.		$	

As part of an investigation of a pesticide-related incident, I willingly submit the clothing items listed above for laboratory analysis of pesticide residues. I understand that the clothing items will not be returned to me. My signature indicates that I understand and agree to these conditions. I will receive a copy of this signed release.

❑ I would like a copy of the laboratory results. Address Phone number	Signature Print Name

Como parte de una investigación de un incidente relacionado con pesticida, ofrezco voluntariamente los artículos de ropa enumerados arriba para análisis de laboratorio de residuos de pesticida. Entiendo que la ropa no se me devolverá. Mi firma indica que entiendo y accedo a estas condiciones. Recibiré una copia de este permiso firmado.

❑ Quisiera una copia de los resultados del laboratorio. Dirección Teléfono	Su firma Su nombre (letra de molde)

Notes

Sample Collector's Name (Print) Phone		Sample Collector's Signature
Date	Date of Incident	Incident Tracking Number/Project Number
California Department of Pesticide Regulation 1001 I Street Sacramento CA 95814		Attention: